



Franklin County Self-Insurance Plan Pre-Employment Physical

355 West Main Street, Suite 428

Malone, NY 12953

Per Workers' Compensation Self-Insurance Plan Local Law

ALL BOXES ON THIS PAGE MUST BE FILLED IN BY HIRING ENTITY.

Hiring Entity for Doctor to mail form back to:	

Candidate's Name:	
Appointment Date & Time:	
Doctor's Office Address:	

HIRING ENTITY RESPONSIBILITY

Please make sure that you fill out the boxes above for the **Doctor to mail the form back to you with the bill.**

Also please check off the boxes on Page 2 for the doctor to complete through the physical. If you instruct the employee to bring the completed physical back to you from the doctor, please let the doctor's office know prior to the appointment what your intentions are.

The purpose of this physical examination is to provide a basis for evaluating the physical fitness for placement of an employee in a position where he/she may safely work within his/her physical capabilities.

This form has been designed to give the maximum medical information on which to judge employment and to afford maximum protection to the employee and the employer.

The form must be completed in its entirety. The employee is to fill out the **first section** and the physician is to fill out the **second section** and then forward the bill and completed physical to the hiring entity for the hiring authority to sign off as being reviewed prior to hiring the candidate.

Payment: Instructions for Hiring Entity for payment of the Pre-Employment Physical.

Once the hiring authority has reviewed and signed off on the completed physical (last page of physical by the doctor's signature). Please submit physical form along with the bill for the physical to:

**Franklin County Self-Insurance Plan
355 W. Main Street, Suite 428
Malone, NY 12953**

An allowance has been approved for this examination per the Local Law No. 2 and any new resolutions to increase the amount.



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DOCUMENTATION FOR THE PHYSICIAN/PRACTITIONER PERFORMING PHYSICAL EXAMINATION

The examining physician/practitioner should conduct a medical history and administer a medical examination, which must include, but is not limited to, the following **checked** components.

<u>Check</u>		<u>Findings</u>	
		Normal / Negative	Abnormal / Positive
()	Basic Physical		
()	Hearing Test required along with basic physical		
()	Vision Test required along with basic physical		
()	Urinalysis required along with basic physical		
()	Drug Screening (10 panel) required along with basic physical		



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ALL INFORMATION MUST BE FILLED IN BY PHYSICAL CANDIDATE THROUGH TO CANDIDATE SIGNATURE.

Name (Print):		DOB:	Male () or Female ()
Address:		Social Sec. #:	Phone #:

Family Physician:		Department who is hiring you:	
Address of Physician:		Position title being hired for:	

- 1) Have you ever applied for or received a Pension, Workers' Compensation or Disability Benefits? Yes ____ No ____
- 2) Have you ever been treated for: (circle if applicable)
 - a) Impairment of hearing or of sight of either eye? Yes ____ No ____
 - b) Dizziness, fainting, convulsions or stroke? Yes ____ No ____
 - c) Heart disease, high blood pressure, heart attack, irregular pulse, varicose veins, or blood clots? Yes ____ No ____
 - d) Lung Disease, tuberculosis, asthma, emphysema, persistent cough? Yes ____ No ____
 - e) Appendicitis, ulcers, stomach trouble, liver disease, gall bladder disease, hernia, intestinal disease or rectal disease? Yes ____ No ____
 - f) Arthritis, rheumatism, sciatica, gout, or any disorder of the muscles or bones of the back, spine or joints? Yes ____ No ____
 - g) Amputation, fracture, or loss of use of an arm, leg, hand, foot, fingers, or toes? Yes ____ No ____
 - h) Rheumatic fever, syphilis, diabetes, epilepsy, cancer or AIDS? Yes ____ No ____
 - i) Emotional, mental, or nervous disorder? Yes ____ No ____
 - j) Complication with pregnancy or delivery? Yes ____ No ____
 - k) Headaches either frequent or severe? Yes ____ No ____

If yes, please describe: _____

- 3) Have you ever had or been advised to have an operation? Yes ____ No ____, EKG? Yes ____ No ____
X-ray? Yes ____ No ____ If yes, please describe: _____

- 4) Do you take any medications regularly? Yes ____ No ____ If yes, give names of medicines and their dosages.

- 5) Do you have any allergies? Yes ____ No ____ If yes, indicate to what you are allergic.

To be completed by Employee - (Continued)**Franklin County Pre-Employment Physical**

- 6) Does any blood relation have diabetes? Yes ___ No ___; Cancer? Yes ___ No ___; TB? Yes ___ No ___
Heart disease? Yes ___ No ___; High Blood Pressure? Yes ___ No ___
- 7) Do you smoke or chew tobacco? Yes ___ No ___ If yes, how much per day? _____
- 8) Do you drink alcohol? Yes ___ No ___ If yes, how many drinks or beers in an average week? _____
- 9) Do you use "entertainment" or "recreational" drugs? Yes ___ No ___
- 10) In your opinion are you now in good health and fully able to do the work you are applying for? Yes ___ No ___

I HEREBY CERTIFY THAT:

- 1) I have carefully read and completed the foregoing information in the health questionnaire and that my answers are true to the best of my knowledge and belief?
- 2) I agree to such physical examination by a company-designated physician as may be required temporary employment being contingent on the satisfactory passing and approval thereof.
- 3) Any untrue statement made herein or any concealment of facts in this physical examination form shall be considered and accepted by me as just cause for the company to dismiss me from its service regardless of when such facts may be discovered.
- 4) I understand that regardless of the results of this physical, employment is not guaranteed.

I hereby authorize any hospital or doctor to furnish a representative of Franklin County Self-Insurance Medical Department with a complete copy of medical record, including x-ray.

Candidate Signature

TO BE COMPLETED BY PHYSICIAN

Examination: Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Uncorrected: Rt_____ Lt_____ Corrected: Rt_____ Lt_____ Color Vision _____

Regular Hearing: left - normal_____ decreased_____ Hearing Aide: () with () without
right - normal_____ decreased_____

Special Hearing Requirements: Must be completed for Buildings & Grounds, Solid Waste and Highway Personnel only.

Lowest Response Level	Frequency (Hz)			
	500	1000	2000	4000
25 db - Normal				
40 db - Mild Loss				
60 db - Serious Loss				
No response - Severe Loss				

To be completed by Physician - (Continued)**Franklin County Pre-Employment Physical**

	Normal	Abnormal	NE	If abnormal please fill in details.
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen/Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Recommendations: _____

- ☐ I certify that this candidate has no pre-existing permanent disabilities.
☐ I certify that this candidate has the following pre-existing permanent disabilities:

I also certify that this is a true record of the examination of the above candidate and that I find said candidate

☐ qualified in accordance with the Franklin County job specification (**if document attached, please sign & date too**) and have reviewed the above health history and have found that he/she is free from health impairments that may be a potential risk to the patient/client or which may interfere with the performance of his/her duties, including habituation/addiction to behavior altering substances.

☐ not qualified for the following reason(s): _____

<u>Signature of Examining Physician:</u>		<u>Reviewer's Signature at Hiring Authority:</u>
Date:		Date: